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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

050

(I)

2

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10100														
CERTIFICATE OF DEATH														
10094														
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>4 Mo. 8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VA Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5125 Astar Place S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>George Washington Blackwelder</b>					4. DATE OF DEATH Month <b>9</b> Day <b>17</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Concord, N. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>6</b>						
13. FATHER'S NAME <b>Tobe Blackwelder</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Melcom</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>Unk.</b>					17. INFORMANT <b>VA Records - VA Hospital - Perry Point, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis Chronic Bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Prostatic obstruction, carcinoma?</b> DUE TO (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized moderate</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>5-10-61</b> to <b>9-17-61</b> , that <del>the</del> death occurred at <b>4:00 a.m.</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>J. L. Garey</b> 22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b>					22b. DATE SIGNED <b>9-17-61</b> 22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE THEREOF <b>9-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Saloom Presbyterian Church</b>			23d. LOCATION (City, town or county) <b>Concord, N. C.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>WELSEY FUNERAL HOME</b> ADDRESS <b>Concord, N. C.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

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10094



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Concord, N. C.

U. S. A.

Tabo Blackwell

Allen Wilson

Unk.

VA Hospital - Army Point, Md.

Unknown

Polioencephalitis Chronic Bilateral

Unknown

From the operation, conclusion?

Arteriosclerosis Generalized moderate

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x

9-11-61

4:00 a.m. 9-11-61

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*[Handwritten signature]*

J. L. C. M. D.

VA Hospital - Army Point, Md.

Wilson Hospital - Concord, N. C.

9-11-61

Report

Concord, N. C.

SEP 20 1961

Call 1-111

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10095

10101

1. PLACE OF DEATH a. COUNTY <b>Cecil County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>27 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>				d. STREET ADDRESS <b>420 Market Street</b>			
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>B.</b> Last <b>BLANSFIELD</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>18,</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/18/16</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b>19</b> Min.		9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Havre de Grace, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>HUEY BLANSFIELD</b>			
14. MOTHER'S MAIDEN NAME <b>Ella Baker</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>			
16. SOCIAL SECURITY NO. <b>217-052-2680</b>				17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia</b>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/22/61</b> , 19 <b>XX</b> to <b>9/18/61</b> , 19 <b>XXXXXX</b> and that death occurred at <b>2:20A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. Mooney</b>				M.D. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D. (PATHOLOGIST)</b>				22d. ADDRESS <b>VAH, PERRY POINT, MD.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE OF BURIAL <b>9/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cemetery</b>		23d. LOCATION (City, town or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington</b>				ADDRESS <b>Havre de Grace Md</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>				25c. REGISTRAR'S NAME <b>Arthur S. Hays</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(PATROLOGIST)

(PATROLOGIST)

Angel Hill Cemetery

Angel Hill Cemetery

9/15/51

9/15/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10102

10096

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil County</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakton</b>	
c. LENGTH OF STAY IN 1b <b>23 Days</b>		d. STREET ADDRESS <b>Box 269</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VA Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARTIN LUTHER BRAY</b>		<b>4. DATE OF DEATH</b> <b>Sept. 17, 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12-4-77</b>
<b>9. AGE</b> (In years last birthday) <b>83</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days	
<b>11. IF UNDER 24 HRS.</b> Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Warrenton, Virginia</b>	
<b>13. FATHER'S NAME</b> <b>Alpheus Bray</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances Burdess</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes SAW</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>VA. Hospital Records - Perry Point, Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.U. Tract Infection</b> DUE TO (b) <b>Benign Prostatic Hypertrophy.</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (1) (VA hospital) attended the deceased from 8-25-61, 19 to 9-17-61, 19, and that death occurred at 10:30 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Bernard S. Linn</b>		<b>22b. DATE SIGNED</b> <b>SEP 22 '61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr Bernard S. Linn</b>		<b>22d. ADDRESS</b> <b>VAH., Perry Point, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>9/21/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fairfax Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Fairfax, Virginia.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Ullrich 4210 Balair Rd</b>		<b>25a. REC'D BY REGISTRAR</b> <b>SEP 22 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>			

10102

M

Geoff Gandy

Very faint

W. Bond

Martin Turner

White

White

Fanner

Alphonse Gray

Yes

Unknown

O.W. Trust Infection

United Prostate Hypertrophy.

Stenocardiac heart disease

W. Bond

8-23-01

8-23-01

Dr. Edward A. Bond

W.A. Very faint, M.A.

W. Bond

W. Bond



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
10097														
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Md. b. COUNTY Cecil									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Town Point					c. LENGTH OF STAY IN lb 4 Hrs.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City									
					d. STREET ADDRESS									
					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last LEON DELMONT CARLTON					4. DATE OF DEATH Month Day Year Sept. 1, 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 11, 1904		9. AGE (in years last birthday) 57 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY C & D Canal		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Leon D. Carlton					14. MOTHER'S MAIDEN NAME Mary Lucy Buob									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mary A. Carlton Address Ches. City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S SIGNATURE R. C. Dodson M.D. Rising Sun, Md. NAME (Type) DATE SIGNED Sept 1, 1961														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Sept. 4, 1961		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or country) (State) Nr. Chesapeake City, Md.							
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME Donald R. Pippin Elkton, Md.					24a. REC'D BY REGISTRAR DATE SEP 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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101 East Main Street, New York, N.Y. 10002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10105

10099

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VA Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>4714 17th St., No.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Eugene Thurston Cudworth</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>9 10 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-1-1877</b>
<b>9. AGE</b> (In years last birthday) <b>84</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>9</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>6</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Government Worker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Boaton, Mass.</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Not available</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Not available</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>S.A.W</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>VA Records - VA Hospital - Perry Point, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>420.0</b> <b>6 10 61</b> <b>8:25 a.m.</b> <b>161 XXXXXXXXXX</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>6 10 61</b> to <b>9 10 61</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 10 61</b> to <b>9 10 61</b> , and that death occurred at <b>8:25 a.m.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>S. Goldgraben</b> <b>S. GOLDGRABEN</b> NAME (Type)		<b>22b. DATE SIGNED</b> <b>9-12-61</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>S. GOLDGRABEN</b> Chief, Medical Service, VAH, Perry Point, Md.	
<b>22d. ADDRESS</b> <b>Arnington &amp; Son</b>		<b>22e. REC'D BY REGISTRAR</b> <b>SEP 14 '61</b>	
<b>22f. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>		<b>22g. REGISTRAR'S NAME</b> <b>Arthur S. Frank</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE THEREOF</b> <b>9 10 61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Pennington &amp; Son</b>		<b>24. ADDRESS</b> <b>Bayre de Grace, Md.</b>	

(M)

1082

10098

Cell

Virginia

Ferry Point

Memphis

Arlington

VA Hospital

July 17th 8... No.

Eugene Thurston

Godwin

9

10

61

x

White

x

3-1-1977

34

9

U.S.A.

Boston, Mass.

U.S. Government

Government Worker

Not available

Not available

VA Hospital - Ferry Point, Md.

Unknown

S.A.W.

Yes

Arteriosclerosis Heart Disease

x

x

6 10

61

9 10

61

8:25 a.m.

U.S. National Guard, Medical Service, VA, Ferry Point, Md.

Arlington National

Arlington, Virginia

9 10 61

Removal

Removal from Ferry de Grace, Md.

10106

## Reg. Dist. No.

VS A15 (4)  
15M 9/5B

VS A15 (4)  
15M 9/5B

CERTIFICATE OF DEATH

10100

10100

(49)

10100

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10107 Item 23b, Film G296 9/26/61 iwk 10101											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Delaware b. COUNTY New Castle					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point						c. LENGTH OF STAY IN 1b 7yr8Mo. 28days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Willard F. EARL						4. DATE OF DEATH Month Day Year SEPTEMBER 16 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 6 10		9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months Days Hours Min. 3 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Cherry Hill Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Earl						14. MOTHER'S MAIDEN NAME Emma Adams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address VA Records - VA Hospital Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355X Bronchial Pneumonia										INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
DUE TO (b) Chronic Central nervous system disease of unknown etiology										Unk.	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (This hospital) attended the deceased from 12-19-53, 19 to 9-16-61, 19 and that death occurred at 9:40 p.m. from the causes and on the date stated above.											
22a. SIGNATURE J. L. Garey M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9/17/61		
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.						22d. ADDRESS VA Hospital - Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 9/20/61		23c. NAME OF CEMETERY OR CREMATORY Iron Hill Cemetery			23d. LOCATION (City, town or county) (State) Iron Hill, Delaware			
24. FUNERAL DIRECTOR'S SIGNATURE Edward R. Bell						25a. REC'D BY REGISTRAR SEP 21 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Harris		
EDWARD R. BELL FUNERAL HOME Wilmington, Delaware											

10101

10101

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Good  
erry Point  
VA Hospital  
HED 2  
Newark  
Delaware

Willing R.  
X  
6 6 10  
10  
61

Cherry Hill Maryland  
U.S.A.  
Luna Adams

VA Hospital - VA Hospital Ferry Point, Md.  
Unk  
Promoted 1. 1960

Chronic Central nervous system disease of  
unknown etiology

X

12-1-58  
12-1-58  
12-1-58

VA Hospital - Ferry Point, Md.  
Iron Hill Cemetery  
Iron Hill, Delaware  
Edward L. Smith Funeral Home Wilmington, Del.

10108

## CERTIFICATE OF DEATH

Reg. Dist. No.

10102

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>I</b> Last <b>Fahey</b>		4. DATE OF DEATH Month <b>9-</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wakeman Gatchell</b>		14. MOTHER'S MAIDEN NAME <b>Martha Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>John J. Fahey</b>		Address <b>Perryville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Failure</b> <b>212X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <b>Severe Attack of Bronchial Asthma</b> (c) <b>Enlarged Cyst in upper part of both lungs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>9 hrs.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Fibrosis, Obstructive Emphysema, Obesity</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-2-</b> , 19 <b>58</b> , to <b>9-6-</b> , 19 <b>61</b> that I last saw the deceased alive on <b>9-5-</b> , 19 <b>61</b> and that death occurred at <b>3:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Luis M. Guza</i>		DATE SIGNED <b>Cecil Ave.</b>	
PHYSICIAN'S NAME (Type) <b>Luis M. Guza</b>		<b>North East, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-9-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i> <b>Joseph R. Grant</b>		24a. REC'D BY REGISTRAR <b>SEP 11 '61</b>	
ADDRESS <b>North East, Maryland</b>		24b. REGISTRAR'S SIGNATURE <i>Carlton L. Hanna</i>	

1

VS A15 (4)  
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10102

M

10102

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Del</b> b. COUNTY <b>New Castle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> d. STREET ADDRESS <b>RD#2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lee H. Ferguson</b> First Middle Last <b>4. DATE OF DEATH</b> <b>9 6 61</b> Month Day Year						<b>5. SEX</b> <b>M</b> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>10-29 1892</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE (In years last birthday)</b> <b>68</b> <b>10. IF UNDER 1 YEAR</b> <b>19</b> <b>11. IF UNDER 24 HRS.</b> Months Days Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Del.</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b>						<b>13. FATHER'S NAME</b> <b>William Ferguson</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Susanna Bradford</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes WW 1</b> <b>16. SOCIAL SECURITY NO.</b> <b>221-20-3716</b> <b>17. INFORMANT</b> <b>Union Hosp. Record. Elkton, Md.</b> Address						<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b> DUE TO (b) (c)					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>9 6 61</b> Hour a.m. p.m. <b>4 p.m.</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Route 213</b> <b>20f. (City or town)</b> <b>Elkton,</b> <b>(County)</b> <b>Cecil</b> <b>(State)</b> <b>Md.</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>R.C. Dodson</b> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>R.C. Dodson</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DENY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>Rising Sun, Md.</b> <b>Address (Street, city, town, or county)</b> <b>9-6-61</b> <b>DATE SIGNED</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>Sept. 9, 1961</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Head of Christiana</b> <b>22d. LOCATION (City, town, or country)</b> <b>Newark Delaware</b>				<b>23. FUNERAL DIRECTOR</b> <b>R.T. Jones</b> <b>Address</b> <b>Newark, Del.</b> <b>24a. REC'D BY REGISTRAR</b> <b>SEP 11 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>							

MEDICAL CERTIFICATION

UNITED STATES

(M)

(1)

Coast

Union

Hospital

Dec

11, 1933

M

W

10-29 1892

63

Admitted

Del.

U.S.A.

William Johnson

Quarantine

Union Hosp. Record, Hinton, Mo.

Cerebral Hemorrhage

Arterio sclerosis

9-4-31

Route 213

Hinton,

Coast

R.C. Johnson

Maine, Mo.

9-4-31



## CERTIFICATE OF DEATH

Reg. Dist. No. 10104

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>84 S. Main St.</b>		d. STREET ADDRESS <b>84 S. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J.</b> Last <b>Fox</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S., A.P., Gr.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Fox</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-03-0815</b>	
17. INFORMANT <b>Margaret P. Fox, Port Deposit, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>Cancer - Lung &amp; Metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 2 mos</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		
(c) DUE TO		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **June 2**, 19**59**, to **Sept 5**, 19**61**, that I last saw the deceased alive on **Sept 4**, 19**61**, and that death occurred at **5:45 A.M.**, from the causes and on the date stated above.

ACTUAL SIGNATURE <b>G.H. Richards Jr.</b>	M.D. <b>Port Deposit, Md.</b>	ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b>	DATE SIGNED <b>9-5-61</b>
PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr. M.D. Port Deposit, Md.</b>			

22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-8-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wesley Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 8 '61</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8175

9 7 2 3 4 5 6 7 8 9

# 1

FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10105											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				d. STREET ADDRESS 110 Bow St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last VIRGIE MARY FRANCIS						4. DATE OF DEATH Month Day Year Sept. 20 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/1929		9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Un-employed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Holland Shufford						14. MOTHER'S MAIDEN NAME Bertha Robinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 245-40-4874		17. INFORMANT Mrs. Bertha Shufford Elkton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X Fracture base of skull also fracture of both femurs, lower jaw with loss of teeth, compound fracture left tibia and fibula laceration of right leg at the knee. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Walked out in front of truck on rte 40							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11:24 9/20 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) North East		(County) Cecil		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R. C. DODSON, MD.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.					
DATE SIGNED 9/21/61											
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 9/22/61		22c. NAME OF CEMETERY OR CREMATORY West Jefferson		22d. LOCATION (City, town, or country) North Carolina					
23. FUNERAL DIRECTOR ADDRESS Pippin F. A. Donaldson Jr. Elkton, Maryland						24a. REC'D BY REGISTRAR DATE SEP 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(I)

10102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10111

TO BE FILLED BY THE MEDICAL EXAMINER

(M)

(P)

*Michael*

10102 10111 10112 10113 10114 10115 10116 10117 10118 10119 10120 10121 10122 10123 10124 10125 10126 10127 10128 10129 10130 10131 10132 10133 10134 10135 10136 10137 10138 10139 10140 10141 10142 10143 10144 10145 10146 10147 10148 10149 10150 10151 10152 10153 10154 10155 10156 10157 10158 10159 10160 10161 10162 10163 10164 10165 10166 10167 10168 10169 10170 10171 10172 10173 10174 10175 10176 10177 10178 10179 10180 10181 10182 10183 10184 10185 10186 10187 10188 10189 10190 10191 10192 10193 10194 10195 10196 10197 10198 10199 10200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10112

10106

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>				c. LENGTH OF STAY IN 1b <b>52 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Craigtown</b>				d. STREET ADDRESS <b>Craigtown</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Catherine Ann Frederick</b>				<b>4. DATE OF DEATH</b> <b>Sept. 23, 1961</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 8, 1888</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>							
<b>13. FATHER'S NAME</b> <b>Erastus Woods</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Amanda Gregg</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>214-24-6442</b>			
<b>17. INFORMANT</b> <b>Willis H. Frederick, Port Deposit, Md.</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Liver</b> 156.1 DUE TO (b) <b>Repeating Dec 1960 Biopsy revealed</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>Cancer Liver.</b> DUE TO (c) <b>Cancer Liver.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 22, 1961</b> to <b>Sept. 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept. 22, 1961</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>G.H. Richards Jr.</b> M.D. 22b. DATE SIGNED <b>9/24/61</b> 22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr.</b> 22d. ADDRESS <b>Port Deposit, Md.</b> 23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b> 23b. DATE THEREOF <b>9-26-1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Port Deposit, Md. Rural</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>See a. Patterson, Jr.</b> ADDRESS <b>Perryville, Md.</b> 25a. REC'D BY REGISTRAR <b>SEP 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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1011

(M)

Coast

Barryland

Coast

Coast

Port Deposit, Md.

Port Deposit, Md.

Port Deposit, Md.

Christown

Christown

(1)

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Sept. 23

Frederick

Ann

Calverton

7

Dec. 8, 1888

X

Female White

U.S.A.

Pennsylvania

San Rome

House Wife

Greene

Amesbury

Woods

Linette

Port

214-2444 Willie E. Frederick, Port Deposit, Md.

*[Handwritten signature and notes]*

Port Deposit, Md.

G.H. Richards Jr.

Port Deposit, Md.

Assembly Cemetery

1-10-1901

Barryland

Perryville, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10113 CERTIFICATE OF DEATH 10107

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton R.D.</u>		c. LENGTH OF STAY IN TB <u>55yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton R. D.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MISSOURIA TODD GUIBESON</u>				4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1888</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Edward Todd</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Crothers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>James H. Guibeson</u> Address <u>R. D. Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>			
20h. (State) <u>  </u>				21. I certify that (I) (the hospital) attended the deceased from <u>7-20</u> , 19 <u>61</u> to <u>8-18</u> , 19 <u>61</u> , that (I) (the) last saw the deceased alive on <u>7-7</u> , 19 <u>61</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Tillman D. Johnson</u> M.D.				22b. DATE SIGNED <u>9-21-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>				22d. ADDRESS <u>142123 Sinslerly Ave, Elkton, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 21, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Cecil County, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 27 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

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First Nixon P.D. 10101

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10114

10108

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b> c. LENGTH OF STAY in lb <b>142 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3511 18th St., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas N. Hasty</b>		4. DATE OF DEATH Month Day Year <b>9 - 8 - 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-96</b>
9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days <b>8 24</b>	IF UNDER 24 HRS. Hours Min. <b>6 15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Enfield, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Hasty</b>		14. MOTHER'S MAIDEN NAME <b>Annie Wilkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT Address <b>VA Hospital Records - VAH Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Lymphatic Leukemia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>6 Days YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Pyelonephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>4-19 1961</b> , that (b) (the last) <b>3:35 p.m. 9-8-61</b> , and that death occurred at <b>XXXXXX</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. H. Swining</b> M.D.		22b. DATE SIGNED <b>1961</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>9-12-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Daniels Chapel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Enfield, N. C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.S. CORNISH</b> <b>COFIELD FUNERAL HOME- Enfield, N. C.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

0111

0001

Ferry Point, Va.

VA Hospital

1st day

Washington

Director of Columbia

211 18th St., N. E.

Thomas H. Hasty

x

Radio

Radio

Radio

Radio

Radio

Radio

Unknown

VA

VA

VA Hospital Records - VA Ferry Point, Va.

Thomas H. Hasty

Thomas H. Hasty

Thomas H. Hasty

x

4-19-51

3:55 p.m.

Removal of body from cemetery

Removal of body from cemetery

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional, indicate before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>				c. LENGTH OF STAY IN 1b <b>15 yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>HOHN</b> Middle <b>HENRY</b> Last <b>HUFF</b>				4. DATE OF DEATH Month <b>9</b> Day <b>1</b> Year <b>19 61</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-1903</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Henry Huff</b>				14. MOTHER'S MAIDEN NAME <b>NO RECORD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>247-01-9922</b>		17. INFORMANT <b>Mrs. John Henry Huff, Cecilton, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary <del>Arterio</del> Occlusion</b>							
DUE TO (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>9-1-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CECILTON Col. Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>CECILTON Cecil Co. MD.</b>	
23. FUNERAL DIRECTOR <b>Edward Fellows, Millington, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

10110

10-01

MA.

Geoliton

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Geoliton

Geoliton

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HUNT

HENRY

JOHN

22

3-10-1903

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1

U.S.A.

U.S.A.

General

Labovay

John Henry Hall

21-1-1922 Mrs. John Henry Hall, Geoliton, MD.

no

Acute coronary thrombosis

X

X

X

X

2-1-01

Prison, Md.

W.C. Dobson



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10116

10110

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R D # 1 Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R D # 1 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rte 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS RICHARD KEITHLEY</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Signalman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James J. Keithley</u>		14. MOTHER'S MAIDEN NAME <u>Susan Heath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary E. Keithley</u>		Address <u>Nr. Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>died instantly</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO <u>unknown</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>61</u> , to <u>Sept. 6</u> , 19 <u>61</u> that I last saw the deceased alive on <u>Sept. 4</u> , 19 <u>61</u> , and that death occurred <u>8:30a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>233 E. Main Street</u> <u>9/6/61</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton</u> <u>Maryland</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 9, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>SEP 11 '61</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

(M)

No. 123456789

State of New York

County of New York

City of New York

Death of

John Doe

Age 45 years

Occupation

Residence

Cause of Death

Signature

Date

Place

Signature

Date

Place

## CERTIFICATE OF DEATH

10117

10111

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>78 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VA Hospital</b>				d. STREET ADDRESS <b>Box 161</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy</b>		First <b>D.</b>		Middle <b>Leggett</b>		Last <b>16X-1</b>	
4. DATE OF DEATH <b>9</b>		Month <b>2</b>		Day <b>19</b>		Year <b>61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 24 92</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>8</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harrison County, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Leggett</b>				14. MOTHER'S MAIDEN NAME <b>Eretta Bates</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Unknown</b>		Address <b>VA Hospital Records - Perry Point, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Gastric Fistula Following Operation</b> DUE TO (c) <b>Carcinoma Of The Stomach</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 To 4 Weeks</b> <b>2 Months</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 16 61</b> to <b>9 2 61</b> , that <del>XXXXXX</del> <b>3:30</b> , and that death occurred at <b>2:30</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. MOONEY</b>				M.D. <b>A. L. MOONEY, M.D., Asst Clinical Pathologist, VAH., Perry Point, Md.</b>		22b. DATE SIGNED <b>9-2-61</b>	
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>		23b. DATE THEREOF <b>9-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Ft Myer, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>CUNNINGHAM FUNERAL HOME</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

1

Geoff  
Perry Point  
VA Hospital

Male  
White  
Maintenance Man  
Heavy Luggage  
Yes  
No

70 days

Langland  
Bowie  
Box 161

W. N.  
x  
5 24 92

8 3 63  
Harrison County, West Va. U. S. A.

Griffin Kates

Unknown  
Unknown  
Gastro Pains Following Operation  
Unknown  
Unknown

9 2 61  
6 16 61  
x

VA Hospital, Perry Point, Md.

10 days

VA Hospital

VA

10118

CERTIFICATE OF DEATH

Reg. Dist. No. 10112

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DEL</u> b. COUNTY <u>NEW CASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union, Elkton, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL D. MARTEN</u>		4. DATE OF DEATH Month Day Year <u>9 25 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/97</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>SAMUEL P. LOELAND</u>		14. MOTHER'S MAIDEN NAME <u>ELLA NEALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS EMMA D. SMITH</u>		Address <u>Somerville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AND, Nephrosclerosis</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Sclerosis, CVA on multiple occasions</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u> <u>5-7 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>9/25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/25</u> , 19 <u>61</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>9/25/61</u> ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D. PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS MD</u> <u>ELKTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-1-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Georges</u>		22d. LOCATION (City, town, or county) (State) <u>St. Georges DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

1. Name of deceased: *John Doe*  
2. Age: *45*  
3. Sex: *Male*  
4. Race: *White*  
5. Date of death: *Jan 15 1912*  
6. Place of death: *St. Louis, Mo.*  
7. Cause of death: *Heart disease*  
8. Signature of physician: *J. H. Smith*  
9. Signature of registrar: *W. B. Jones*  
10. Signature of undertaker: *John Doe*  
11. Signature of funeral home: *St. Louis*  
12. Signature of cemetery: *St. Louis*  
13. Signature of church: *St. Louis*  
14. Signature of family: *St. Louis*  
15. Signature of friends: *St. Louis*  
16. Signature of neighbors: *St. Louis*  
17. Signature of community: *St. Louis*  
18. Signature of country: *St. Louis*  
19. Signature of world: *St. Louis*  
20. Signature of universe: *St. Louis*



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>H.</b> Last <b>Maucher</b>		4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/1906</b>
9. AGE (In years lost birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>Colwyn, 1 Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry J. Maucher</b>		14. MOTHER'S MAIDEN NAME <b>Sara Halfpenny</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Margaret M. Maucher</b>		Address <b>Blue Ball Road Elkton R.D. #3</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>590X Uremia coma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Interstitial Nephritis</b> DUE TO (c) <b>Secondary Anemia, Cerebral Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Anemia, Cerebral Anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 31, 1961</b> to <b>Sept. 3, 1961</b> , that I last saw the deceased alive on <b>September 2, 1961</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>245 E. 11th St. Elkton, Md.</b> DATE SIGNED <b>9/4/61</b>			
ACTUAL SIGNATURE <b>James R. Johnson</b> M.D.		PHYSICIAN'S NAME (Type) <b>James R. Johnson M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/7/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Collingdale, P. Collingdale, Penna.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>		24a. REC'D BY REGISTRAR <b>SEP 6 '61</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence Before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>						c. LENGTH OF STAY in 1b <b>19yrs. 7mo. 20days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>4905 - 7th Street, N.W.</b>					
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>E.</b> Last <b>NEACEY</b>						4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-6-93</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleswoman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME <b>James P. Neacey</b>						14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Creveling</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW-I</b>						16. SOCIAL SECURITY NO. <b>Not available</b>					
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cholecystitis</b> DUE TO (b) <b>585X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>585X</b> DUE TO (c) <b>585X</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelitis, chronic</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>VA</b> 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XXXXXXXXXX</del> attended the deceased from <b>January 22 19 42</b> to <b>Sept. 11, 1961</b> and that death occurred at <b>1:40 pm</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>S. Goldcraben</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>9-11-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN</b>						22d. ADDRESS <b>Chief, Medical Service, VAH, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-14-61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) <b>Washington, D. C.</b>		(State)			
24a. SIGNATURE <b>Timothy Hanlon</b>						24b. ADDRESS <b>3831 Georgia Ave. NW</b>		24c. REC'D BY REGISTRAR <b>SEP 14 '61</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

18132



Geoff

Director of Columbia

erry Tinto

1977. Two. 20 days

Washington

Veterans Administration Hospital

4905 - 72 Street, N.W.

7

MARIE

HEADY

September 11

61

Female

White

2-6-33

63

Unemployed

Dept. Store

Washington, D. C.

USA

James P. Hickey

Katy Elizabeth Overling

Yes  
WW-I  
Available  
Not

Hospital Records, War, Perry Point, Md.

Source Unreliable

Psychic, chronic

January 22, 42 Sept. 11

1:40 pm

2-11-61

U. S. Soldiers Civil Medical Service, War, Perry Point, Md.

Washington, D. C.

Mr. Oliver

3821 Georgia Ave. NW

Timothy Nathan Lane Home, Wash. D. C.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10115

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of this certificate is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>		c. LENGTH OF STAY IN lb <b>many years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Norah</b> Middle <b>F.</b> Last <b>Preston</b>				4. DATE OF DEATH Month <b>9</b> Day <b>5</b> Year <b>19 61</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b>	IF UNDER 24 HRS. Hours <b>78</b> Min. <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Sally Heaton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Creswell</b> Address <b>Raymond <del>07222</del> Port Deposit, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage with paralysis</b> DUE TO (b) <b>331X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-8-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	
				22d. LOCATION (City, town, or country) (State) <b>Rocks, Harford Co., Md</b>			
23. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

STATE OF  
NEW YORK

(M)

Cecil

Md.

Cecil

Port Deposit, Md.

many years

Port Deposit, Md.

Nov.

Preson

May 3 1883

78

House wife

Md.

U.S.A.

William Fletcher

2214

Preson

no

none

Raymond 222222 Port Deposit, Md.

Cerebral Hemorrhage with paralysis

R. J. Dobson

Living 2nd, Md.

2-2-01



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10116

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any medical director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 hr.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs		d. STREET ADDRESS R.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John S. Rees		4. DATE OF DEATH Sept. 22, 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1909 52 yrs.		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Storekeeper		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Rees		14. MOTHER'S MAIDEN NAME Catherine Spence		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Mrs. Margaret Bouchelle Rees, Childs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac condition for over a year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE R. C. Dodson		EXAMINER'S NAME (Type) R. C. Dodson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/23/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Head of Christiana Cemetery, Newark, Delaware		22d. LOCATION (City, town, or country) Rising Sun, Md.		(County)		(State)							
23. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR SEP 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline											

MEDICAL CERTIFICATION

7-0122 MEDICAL RECORDS - DEATH 10116

(M)

11-11-1916

11-11-1916

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10123

10117

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CECIL</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> <span style="float: right;">c. LENGTH OF STAY IN lb</span> <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DIVINE NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>HARFORD</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> d. STREET ADDRESS <u>1224</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY</u> <span style="float: right;">First Middle Last</span> <u>ELIZ. RICHARDSON</u> <b>4. DATE OF DEATH</b> <u>SEPT. 13</u> <span style="float: right;">Month Day Year</span> <u>1961</u>				<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JAN. 1, 1866</u> <b>9. AGE</b> (In years last birthday) <u>95</u> <span style="float: right;">IF UNDER 1 YEAR</span> <input type="checkbox"/> <span style="float: right;">IF UNDER 24 HRS.</span> <input type="checkbox"/> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RETIRED</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>JOHN WERNER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>REGINA SITZLER</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <u>Mrs. Dorothy SPENCER Havre Grace MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>unknown</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 6</u> , 19 <u>61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept. 12</u> , 19 <u>61</u> , <b>and that death occurred at</b> <u>9:46a</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>S. Ralph Andrews, Jr.</u> <span style="float: right;">M.D.</span>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>9/13/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>S. RALPH ANDREWS, JR., M.D.</u>				<b>22d. ADDRESS</b> <u>233 E. Main St., Elkton, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>9-16-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ANGEL HILL</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>HAVRE DE GRACE MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Madison Mitchell</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MA</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

2507

520

1020-11511

1. Psychiatric  
 2. Physical  
 3. Chemical  
 4. Biological  
 5. Environmental  
 6. Social  
 7. Economic  
 8. Political  
 9. Cultural  
 10. Religious  
 11. Philosophical  
 12. Artistic  
 13. Scientific  
 14. Technological  
 15. Medical  
 16. Legal  
 17. Ethical  
 18. Moral  
 19. Historical  
 20. Geographical  
 21. Demographic  
 22. Statistical  
 23. Mathematical  
 24. Physical  
 25. Chemical  
 26. Biological  
 27. Environmental  
 28. Social  
 29. Economic  
 30. Political  
 31. Cultural  
 32. Religious  
 33. Philosophical  
 34. Artistic  
 35. Scientific  
 36. Technological  
 37. Medical  
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355

R. HALPH ANDREWS, JR., W.D. 200 E. Main St., NIKON, INC.

10124

CERTIFICATE OF DEATH

10118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>4 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural --- North East, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital of Cecil County</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cordelia</u> Middle <u>A.</u> Last <u>Roark</u>				4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1874</u>		9. AGE (In years lost by day) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Moses Price</u>				14. MOTHER'S MAIDEN NAME <u>Almedia Pope</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mr. Duffie L. Roark, North East, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PT. cerebral thrombosis with left hemiplegia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>8/19</u> , 19 <u>61</u> , to <u>9/14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>61</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D.				ADDRESS (Street, city or town, state) <u>North East, Md.</u> DATE SIGNED <u>9/15/61</u>			
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 27 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

1911

CERTIFICATE OF DEATH

WILLIAM A. J. JAMES  
BORN 1874  
DIED 1911

(M)



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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FOR STATE  
HEALTH DEPT.

Item 20 Film 295 9-19-61 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10120											
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Pa.</b> b. COUNTY <b>Lancaster</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster</b>					
c. LENGTH OF STAY IN 1b <b>48 hrs.</b>						d. STREET ADDRESS <b>35 S. Ann. St.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Melvin Strohm Steffy</b>						4. DATE OF DEATH <b>9 8 19 61</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>				11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ivan W. Steffy</b>						14. MOTHER'S MAIDEN NAME <b>Effie Strohm</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W.W.2</b>						16. SOCIAL SECURITY NO. <b>173-035781HA</b>					
17. INFORMANT <b>Ivan W Steffy, 6040 Lemon, St. E. Petersburg.</b>						Address <b>Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowned</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of Item 18.) <b>Was repairing boat in Susquehanna River Marina Boat Wharf</b>							
20c. TIME OF INJURY <b>5.05 p.m.</b> <b>9 8 19 61</b>				20d. INJURY OCCURRED <b>While at work</b> <input checked="" type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boat Yard</b>		20f. (City or town) <b>Port Deposit Cecil</b> (County) <b>Md.</b> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>R.C. Dodson</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Rising Sun, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>9/11/1961</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cem.</b>						22d. LOCATION (City, town, or country) <b>Lincoln Pa.</b>					
23. FUNERAL DIRECTOR <b>Comm E. M. Miller</b>						24a. REC'D BY REGISTRAR <b>Rising Sun, Md.</b>					
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					
						DATE <b>SEP 13 '61</b>					

# 0122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10120

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Pa.

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Ellie Strohm

Ivan W. Stally

Ivan W. Stally, 6000 Jason, St. R. Petersburg, Fla.

W.W.S.

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Drowned

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Port Deposit Cecil

X Boat Yard

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9-19-01

Stally Sun, Md.

P.O. Hobson

Lincoln Co.

Stally Sun, Md.

Stally Sun, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10127

## CERTIFICATE OF DEATH

10121

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> <span style="float: right;"><b>Kent</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sassafras</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Edward</b> Last <b>Waecker</b>		<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>15</b> Year <b>1961</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Del.</b>			
<b>13. FATHER'S NAME</b> <b>John Waecker</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>No Record</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>218-34-9499</b>		<b>17. INFORMANT</b> <b>Mrs. Anna Waecker,</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple embolism and thrombosis.</b> DUE TO (b) <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene rt leg, far-advanced arteriosclerosis.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>  (County)		(State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 1961</b> <b>to</b> <b>15 Sept 61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>15 Sept 61</b> , <b>and that death occurred at</b> <b>7:00 AM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Wallace Obenshain</i>				<b>22b. DATE SIGNED</b> <b>18 Sept</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wallace Obenshain, M.D.</b>				<b>22d. ADDRESS</b> <b>Cecilton, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Sept. 18, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Galena Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Galena, Kent Co;</b>		(State) <b>Md.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edward Fellows</i>				<b>25a. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kraus</i>			
<b>25b. ADDRESS</b> <b>Millington, Md.</b>				<b>25c. DATE</b> <b>SEP 20 61</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Item 22 Film G297 10/2/61 mh

10128

# CERTIFICATE OF DEATH

Reg. Dist. No.

10122

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. STREET ADDRESS <b>129 East Main St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edith</b>		First <b>S.</b>		Middle <b>Walmsley</b>		Last <b>9</b>	
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/22/1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank R. Scott.</b>				14. MOTHER'S MAIDEN NAME <b>Rachel J. Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>+</b>		16. SOCIAL SECURITY NO. <b>+</b>		INFORMANT <b>Mrs T. Coleman Johnson Wilmington, Del.</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1810</b> DUE TO <b>Carcinoma of the bladder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN DEATH AND EXAMINATION <b>several yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intestinal obstruction caused by metastatic lesion</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 10</b> to <b>Sept. 24</b> , that I last saw the deceased alive on <b>Sept. 23</b> , and that death occurred at <b>6:45 a. m.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>233 E. Main Street</b>		DATE SIGNED <b>9/24/61</b>			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>		M.D. <b>S. Ralph Andrews, Jr., M.D.</b>		Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walker on Bond</b>		ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. H.</b>	

CERTIFICATE OF DEATH

10158

10158



10158

10158

10158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Lloyd</b> Middle <b>A.</b> Last <b>White</b>		4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1895</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas White</b>	
14. MOTHER'S MAIDEN NAME <b>Carrie A. Johnson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>218-20-5523</b>		17. INFORMANT <b>Pearl White, 21 Pine St., Wilmington, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>1 yr.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July - 7 - 1961</b> to <b>Sept 5, 1961</b> , that I last saw the deceased alive on <b>Sept 5 - 1961</b> , and that death occurred at <b>7:30</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence F. Benson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Port Deposit, Md. Sept 6 1961</b>	
PHYSICIAN'S NAME (Type) <b>Clarence F. Benson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 9, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond (Col.)</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Zenneth Walby</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

CERTIFICATE OF DEATH

1915

NAME OF DECEASED John		MARRIAGE Married		DEATH Death	
PLACE OF BIRTH Maryland		PLACE OF DEATH Maryland		DATE OF DEATH 1915	
AGE 25		SEX Male		RACE White	
OCCUPATION Farmer		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF BIRTH 1890		DATE OF DEATH 1915		PLACE OF DEATH Home	
NAME OF DECEASED John		MARRIAGE Married		DEATH Death	
PLACE OF BIRTH Maryland		PLACE OF DEATH Maryland		DATE OF DEATH 1915	
AGE 25		SEX Male		RACE White	
OCCUPATION Farmer		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF BIRTH 1890		DATE OF DEATH 1915		PLACE OF DEATH Home	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10130

## CERTIFICATE OF DEATH

Reg. Dist. No. 10124

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION home of sister		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Willis (Emily) Willis		4. DATE OF DEATH Month Day Year Sept 9 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	9. AGE (In years last birthday) yrs. 62
11. BIRTHPLACE (State or foreign country) usa		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Robert Lee Alderson		14. MOTHER'S MAIDEN NAME Ella Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-9905	
17. INFORMANT Mrs. E Wm. Lynch		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the ovary with metastases 17 5.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 months.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 61 to Sept 9 61, that I last saw the deceased alive on Sept 9 19 61, and that death occurred at 6:00p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain		ADDRESS (Street, city or town, state) Cecilton, Md.	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		DATE SIGNED 9 Sept 61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 12, 1961	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE SEP 13 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus





VS. A15ME  
5M 7/59

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Julius & Emma

10125

(M)

(T)

W.C. C. C. C.

W.C. C. C.